NEW YORK STATE
OFFICE OF ADDICTION SERVICES AND SUPPORTS

REVOKED ON_____Staff sig_____

CONSENT FOR RELEASE OF INFORMATION CONCERNING PERSONS WITH A SUBSTANCE USE DISORDER IN A FACILITY AND THEIR GENERAL MEDICAL CONDITION

PATIENT'S LAST NAME	FIRST	M.I.
CASE NO.		
FACILITY		

INSTRUCTIONS: **GIVE A COPY OF THE FORM TO THE PATIENT!** Prepare one (1) copy for the Patient's Case Record

I, the undersigned, authorize the staff of this facility to say that I am present or not at this facility and provide information about my general condition to those persons listed below who are personally interested in my whereabouts and progress. I agree to have my next of kin as listed below notified in case of injury, illness or other emergency.

Name of Next of Kin	Telephone
Address	

NAME(S) OF INTERESTED PERSONS	RELATIONSHIP

I understand that this consent may be withdrawn by me, in writing, except to the extent authorized information has been disclosed in reliance upon it. In any event, this consent shall expire one (1) month after my discharge from this facility. I also understand that any disclosure made on my behalf by this facility is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of substance use disorder records as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

_____
(Signature of Patient)

_____
(Signature of Parent/Guardian, when required)

_____
(Print Name of Patient)

_____
(Print Name of Parent/Guardian)

_____
(Date)

_____
(Date)